

Why Is Providing Dental Care to People with Mental Retardation and Other Developmental Disabilities Such a Low Priority?

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[I]n 1957 . . . a course of study in dental care for handicapped children was relatively new to the dental school curriculum [I]t was not considered an essential part of the dental school curriculum even as recently as the early 1970s¹

In the past, individuals with severe disabilities were often neglected by the dental profession because of: (a) a lack of basic knowledge regarding the patient and appropriate physical and/or psychological management, (b) lack of experience, (c) assumed disruption of the office routine, (d) presumed need for special facilities and equipment, and (e) inadequate compensation for increased time involvement in treatment.² But after 50 years of experience, why is dental care for people with mental retardation and other developmental disabilities (MR/DD) such a continuing low priority? Maybe because these concerns continue, but with added significance.

Only after all is said and done with the nondisabled community do people with disabilities get any attention.³

A LACK OF BASIC KNOWLEDGE

Repeated studies have shown that dental school graduates do not gain the necessary expertise to treat patients with MR/DD. The results of a national study of U.S. and Canadian dental schools carried out at the end of the 1990s, with information supplied by faculty/administration,⁴ showed actual decreases in the allocation of time for the training of students in the care of services for individuals with MR/DD over the four years of education:

- More than half of the schools provided less than five hours of didactic training.^{4,5}
- Almost three-quarters of the schools provided 5% or less of clinic time for care of patients with MR/DD.^{4,5}

The results of a regional 2001 study of third- and fourth-year dental students' attitudes, beliefs, and training experience related to individuals with mental retardation mirrored the findings of the previous studies:

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- Almost two-thirds (63%) of students reported that they had never treated an individual with mental retardation.⁶
- 82% of students reported less than five hours of didactic time devoted to treating individuals with mental retardation.⁶

A national study of dental hygiene programs reported comparable findings:

- 48% of 170 programs had 10 hours or less of didactic training (including 14% with five hours or less).⁷
- 57% of programs reported no clinic experience.⁷

The inadequacies in the preparation of dental school and dental hygiene school graduates have been demonstrated repeatedly during the didactic and clinic training programs that the Special Smiles component of Special Olympics has carried out throughout the United States for more than eight years (Unpublished data, Special Olympics, 2001).

THE PLAYING FIELD HAS CHANGED

As a result of developments since the mid-1950s in the care of individuals with MR/DD (including the development of psychoactive drugs, “deinstitutionalization,” “mainstreaming,” and “inclusion”) have increased this population’s dependency for dental (and other health services) on community practitioners.⁸

In the 30-year period through the end of the 1990s, the number of institutionalized residents with MR/DD decreased by 75%.⁹ The number of residents with MR/DD residing in psychiatric institutions decreased by 91%.⁹ Specifically, in the mid-1960s, there were more than a quarter of a million individuals with MR/DD in state institutions.⁹ By the late 1990s, there were fewer than 58,000 residents with MR/DD in state facilities.⁹ In addition, untold thousands of youngsters and adults have remained with their families as state institutions have been shut down.

In the past, large state institutions (to some degree) offered a wide range of in-house health services provided by medical and dental staff. Almost all of the current community residential facilities, however, are too small in size to provide in-house services beyond the annual examinations that are required in some states. As a consequence, the monitoring and delivery of health care can be difficult when services and health records are divided among multiple providers and locations.

Although no national studies provide a general view of the dental needs of people with MR/DD, local studies, including one of Independent Living Centers in

Massachusetts indicate particular needs for services.¹⁰⁻¹² People with disabilities experience the same general dental health problems as people who are not disabled, but for many of the former, these conditions serve as added impediments. Nevertheless, “while there is increased awareness of the need to improve access to quality medical services [for individuals with disabilities], dentistry has largely been ignored.”¹³

DENTAL STUDENT AND PRACTITIONER CIRCUMSTANCES HAVE CHANGED

Decreased numbers of dental students, marked increases in student debt, changes in practitioner-to-population ratios, third party economics, and related developments are contributing factors to the low priority given to the dental care of individuals with MR/DD.

Number of dental students

During the past 30 years, there have been wide swings in the numbers of applicants to, and first-year places in, schools of dentistry. From 1970 to 1975, there was a 77% increase in the number of applicants (from 8,878 to 15,734 applicants), followed by a two-thirds decrease to approximately 5,100 applicants in 1990, and in turn, by an increase to 9,000 applicants in 1999 (Table 1).¹⁴⁻¹⁶ The number of first-year places in dental schools mirrored these wide swings, with first an increase, followed by a one-third decrease and a more recent slight increase. (There were times in the late 1980s when the number of applicants almost approximated the number of entering places.) The largest number of first-year places was in 1978 (6,301), the smallest applicant-to-entering place ratio since 1950 was in 1988 (1.26), and the smallest number of entering places since 1966 was in 1989 (3,979).

Table 1. Applicants and first-year enrollees in U.S. dental schools: selected years, 1970–1999

Year	Number of applicants	Number of enrollees	Ratio of applicants to enrollees
1970	8,878	4,565	1.94
1975	15,734	5,763	2.73
1980	9,601	6,030	1.59
1985	6,216	4,633	1.34
1990	5,123	4,001	1.28
1995	8,437	4,237	1.99
1999	9,010	4,209	2.14

SOURCES OF DATA: References 14–16.

Table 2. U.S. population and number of private dental practitioners: selected years, 1976–2002, and future projections

Year	U.S. resident population (millions)	Number of active private dental practitioners	Number of active private practitioners per 100,000 population
1976	217.6	100,051	46.0
1982	231.7	116,208	50.2
1987	242.3	126,357	52.2
1992	254.9	140,349	55.1
1997	271.2	151,309	55.8
2000	281.4	153,431 ^a	54.5 ^a
2010	306.5 ^a	163,328 ^a	53.3 ^a
2020	332.1 ^a	168,528 ^a	50.7 ^a

SOURCE: Reference 14.

^aPreliminary estimates.

Number of dental practitioners

The overall result of the “roller-coaster” ride during the past three decades in the number of dental students was a 50% increase in the number of active private practitioners, and until 1997, increases in the practitioner-to-population ratio (Table 2).¹⁴ As a result of the continuing increase in the general population and a one-third decrease in the number of dental school entering places, a progressive decline in the practitioner-to-population ratio during the next 20 years is projected (Table 2).

In terms of the increasing practitioner-to-population ratios through the late 1990s, one might assume that practitioners would be eager to increase their prospective pool of patients—even patients with MR/DD. But other factors are involved.

Student debt and employment

From the early 1980s to the late 1990s, the mean debt of graduating dental students more than tripled, reaching \$84,000 in 1998 (an increase of 87% in terms of constant dollars—i.e., with the effects of inflation removed) (Table 3).¹⁴

The annual tuition in some dental schools is more than \$40,000. The mean debt of dental students who had debts in 2000 was \$106,000.¹⁷ This was 13% larger than the mean debt of medical students with debts (\$94,000). Increased numbers of dental school graduates have sought employment and/or postdoctoral education in advanced general dentistry programs in an effort to pay off mounting debts.¹⁷

The employment of increased numbers of dental auxiliaries together with greater numbers of new dental school graduates have dramatically changed the average dental establishment.^{18–20} In 1980, 69.1% of den-

tal facilities had fewer than five employees.¹⁸ (Employees may include dentists, dental hygienists, dental assistants, office staff, etc.) By 1999, despite an increase of almost 30,000 establishments, there was a decrease by more than 6,000 of these smaller dental establishments.²⁰ By the end of the 1990s, 45.9% of dental establishments had fewer than five employees²⁰ (Table 4).

Should recent dental graduates (and dental hygienist graduates) join ongoing larger practices as employees or junior partners, they may have limited opportunities to alter established priorities in patient selection. Thus, they still may not gain sufficient experience in the care of patients with special needs since most private practices exclude these patients from their patient pools. (The reality for this exclusion is that dentists who are willing to treat individuals with disabilities are often inundated with referrals from colleagues who are not so inclined.⁴)

Table 3. Graduating dental student debt: selected years, 1982–1998

Year	Mean debt in current dollars (thousands)	Mean debt in constant dollars ^a (thousands)
1982	26.6	44.9
1986	37.2	55.3
1988	39.3	54.2
1990	54.6	68.0
1992	55.6	64.5
1994	62.8	69.0
1996	75.7	78.7
1998	84.1	84.1

SOURCE OF DATA: Reference 14.

^aConstant dollar base = 1998.

Table 4. Distribution of dental establishments by number of employees: 1980, 1990, 1999

Number of employees	Percent of establishments		
	1980	1990	1999
1–4	69.1	55.0	45.9
5–9	25.5	34.2	38.4
10–19	4.7	9.5	13.6
20–49	0.6	1.2	1.9
≥50	<0.1	0.1	0.1

SOURCES OF DATA: References 18–20.

THIRD PARTY ECONOMICS

[O]verhead patient care run(s) between 60–70% of the dental fees and a cost of just under \$10.00 per office visit for regulatory compliance, primarily including mandated infection control and OSHA regulatory compliance.²¹

In 1999, the Dental Society of the State of New York, private dentists, and parents brought an action in U.S. District Court against the governor, the Acting Commissioner of Health, and the Director of the Division of the Budget. The complaint alleged that:

- “[The] inadequate Medicaid fee schedule discourages dentists from participating in the program and frustrates the mandate of the Medicaid law”²¹
- New York’s dental fees represent reimbursement rates of between 10 and 30% of the usual and customary fees established by private insurance carriers for their New York City insured [enrollees]”²¹
- Nationally, constant dollar per-patient Medicaid dental expenditures have continued to decrease

since the mid 1970s.^{22–25} In 1998, Medicaid constant dollar expenditures per patient were less than half of the rate in 1975 (Table 5). In addition, since the mid-1980s, expenditures for dentistry have represented a decreasing share of all Medicaid health spending.²⁶

Now add these realities:

- Medicaid serves as a primary source of funding for dental services for a significant proportion of youngsters with MR/DD.²⁷
- Medicaid dental care is mandated for eligible children under the Early Periodic Screening, Diagnostic and Treatment Program. But, only about one in five Medicaid-eligible children receive any preventive dental services by age 20.²⁷
- Medicaid dental care for adults is an elective service. In many states, Medicaid dentistry is limited to emergency care—usually limited to extractions.²⁸ As a result, “Children with disabilities are aging out of dental care.”²⁹

Administrative and paperwork frustrations as well as a particularly high incidence of appointment “no-shows” only add to the frustration and limited practitioner participation in the Medicaid dental program.²⁸

But most significant is the long-term limited government support for all aspects of dental care. For example, in 1999, combined federal, state, and local government spending for all dental care represented 4.6% of national dental expenditures, compared to 32.3% of physician expenditures and 59.5% of hospital care spending.²⁵

And these economic shortcomings do not take into consideration the often added time and expenses associated with the dental care of individuals with MR/DD!

Table 5. Expenditures for Medicaid dental patients: selected years, 1975–1998

Year	Expenditures for dental care in dollars (millions)	Number of patients (thousands)	Expenditure per patient in current dollars	Dental CPI ^a	Expenditure per patient in constant dollars
1975	339	3,944	85.95	52.2	164.66
1980	462	4,652	99.31	78.9	125.87
1985	458	4,672	98.03	114.2	85.84
1990	593	4,552	130.27	155.8	83.61
1995	1,019	6,383	159.64	206.8	77.20
1998	901	4,965	181.47	236.2	76.82

SOURCES OF DATA: References 22–25.

^aDental component of the Consumer Price Index, based on: 1982–1984 = 100.

REALITIES AND CHALLENGE

Among the 53 million adults with disabilities in the United States in 1997, 33 million had a severe disability and 10 million needed assistance in their daily lives [including millions with MR/DD].³⁰

Given the realities of increased numbers of individuals with MR/DD living in local communities dependent for care on local dental practitioners, projected decreases in the private dental practitioner-to-population ratios, limited dental and dental hygiene school training opportunities, increasing dental graduate debts, changed practice arrangements with increasing number of employed dentists in established practices, and limited third party reimbursements, particularly by government agencies, is there any reason to believe that there will be any change in the certainty that providing dental care for individuals with MR/DD will continue to be a low priority?

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